Ending Homelessness Among Older Adults: A Blueprint for Action

Ensuring All Older Adults in Massachusetts Have a Safe, Stable, & Affordable Home

May 2014

I. Vision and Blueprint Goals

The Blueprint for Ending Homelessness among Older Adults has an urgent vision: all older adults in Massachusetts will have a safe, stable, and affordable home. The Blueprint is designed to articulate strategies that will prevent older adults from becoming homeless and to rapidly rehouse and stabilize those experiencing homelessness.

II. *Executive Summary*

The Interagency Council on Housing and Homelessness, in partnership with the Executive Office of Elder Affairs (EOEA), formally launched the Older Adult Steering Committee in 2013. A list of members is included in Appendix A. The group's goal is to outline a set of short- and longer-term action items to prevent and end homelessness among older adults. The process of articulating this action plan has proven beneficial in building a coalition among relevant state agencies and community-based partners who are now working toward a shared vision.

The Blueprint Plan provides an overview of the problem of homelessness among older adults in Massachusetts, as well as national and local best practices that served as a guidepost for the recommendations contained in the plan. Last year a survey of 858 homeless older adults confirmed the significance of the challenge and also indicated as many as 40-50% of them are experiencing chronic homelessness. National research has also been growing in recent years, providing even stronger evidence of the social and systems costs. The National Alliance to End Homelessness has begun to document the increase in homelessness among older adults as a percentage of the population, and warns that economic and policy circumstances for the baby boom generation may be leading to larger increases among this cohort.

The ICHH Older Adult Working Group engaged a variety of state and nonprofit stakeholders over the course of a year to develop this Blueprint Plan. The recommendations are contained on pages 8-10 of this report and are broken into two sections: a short-term action plan and a long-term action plan. The Working Group agreed that immediate steps should be taken to launch the overall effort, but given the timing with the fiscal year additional resources would be limited until at least 2015. Therefore, the recommendations contained in the short-term action plan are heavily focused on policy initiatives and the development of key partnerships. Recommendations requiring additional resources are contained in the long-term action plan.

The Working Group has organized its short and long-term action steps within an 8 Goal Framework:

- **Goal 1:** ***Increase awareness of homelessness among older adults***
- **Goal 2:** ***Strengthen existing homelessness initiatives to include older adults as a priority population***
- **Goal 3:** ***Improve data quality to understand the scope of homelessness among older adults and track progress in prevention and rehousing.***
- **Goal 4:** ***Build partnerships to enhance coordination and maximization of housing and service resources***
- **Goal 5:** ***Explore opportunities for providing older adults who become homeless with safer, more supportive alternatives to emergency shelter.***
- **Goal 6:** ***Prevent at-risk older adults from becoming homeless.***
- **Goal 7:** ***Reduce chronic homelessness among older adults.***
- **Goal 8:** ***Serve homeless and at-risk older adults by using triage and assessment practices designed to ensure targeted application of prevention, rapid rehousing, and stabilization resources.***

III. *Older Adults Homelessness is a Serious and Growing Problem in Massachusetts*

Massachusetts has not published an analysis of HMIS data tracking the number of older homeless adults in shelter, transitional housing (TH), or on the street. Our best estimates of the magnitude of the problem come from surveys disseminated through the Massachusetts Housing and Shelter Alliance network of housing and service providers.

The ***2012*** survey collected information about 957 persons over 50 years old -- 781 persons age 50-61, 176 persons age 62 or older. The ***2013*** survey collected information about 858 persons over 50 years old - 663 persons age 50-61, 195 persons age 62 or older.

The overwhelming majority of persons counted were surveyed by the shelter or Transitional Housing (TH) providers where survey respondents were staying (92% in 2012, 96% in 2013). Much smaller numbers of respondents were surveyed by outreach providers; among respondents surveyed by outreach providers, 26 (about 2.6% of the 2012 respondents) and 10 (about 1.1% of the 2013 respondents) reported staying in non-homeless situations the prior night (e.g., a friend's apartment); many, if not all, of those men and women were presumably technically homeless much of the rest of the time.

The persons counted in these statistics are only a portion of the total number of older homeless persons in Massachusetts. Only a portion of the shelter/TH provider community participated in the survey, and only a small percentage of the unsheltered population was surveyed. In both the 2012 and 2013 surveys, Boston and Metro Boston programs were disproportionately represented among participating providers. The change in the count from 2012 to 2013 is not statistically meaningful, however, because different providers participated in the survey from year to year.

While it should be possible to use the State's HMIS in the future and other strategies to more accurately measure the extent of older adult homelessness in Massachusetts, the survey data describe a large enough problem to justify prompt, focused attention, without waiting for more extensive and time-consuming data/analysis.

Details from the 2013 Survey

Data Category	Percentage Reporting	Breakdown
Gender	94%	80% male, 19.5% female, 0.5% transgender
Age	100%	77% age 50-61, 23% age 62+ (approximately 4 times as many males as females in each group)
Race	95%	54% white, 33% black, 13% other
Ethnicity	94%	13% Hispanic, 87% not Hispanic
Veteran Status	98%	17.5% veterans, 82.5% non-veterans
Education	99%	26% less than HS grad/no GED, 35% GED or HS grad, 7% voc tech, 32% higher ed

Experience of Homelessness[1]:

95% reporting	Never	3 months or less	4-6 months	7-12 months	1-2 years	2-3 years
For what portion of the past 3 years were respondents homeless?	8.5%	10%	12%	18%	21%	30.5%
88% reporting	**Never**	**3 months or less**	**4-6 months**	**7-12 months**	**1-2 years**	**2-3 years**
For what portion of the past 3 years were respondents in a housing situation?	36.5%	7%	5%	10%	17.5%	24%

That is, at least 60% of the respondents spent two out of the past three years homeless.

94% Reporting	Less than 1 Month	1-3 Months	4-6 Months	7-12 Months	1-3 Years	3-5 Years	5-10 Years	More than 10 Years
How long since respondents lived in a housing situation for a (consecutive) month?	3%	8%	8%	15%	28%	14%	13%	10%

That is, for 65% of the respondents (532 men and women), it had been at least a year since the last time they spent a consecutive month in housing, and for 37% it had been over 3 years.

Conservatively, it seems reasonable to conclude that 40 - 50% of the surveyed men and women were chronically homeless.

- To estimate the number of respondents who would be considered to have a ***qualifying disabling condition,*** we counted the number of under-65 persons who receive a disability-related benefit (i.e., SSI/SSDI, EAEDC, or Medicaid) plus any other persons who had received inpatient or residential care for a disabling condition.
- To estimate the number of respondents with a disabling condition whose ***homelessness was of sufficient duration*** to qualify them as chronically homeless, we did two calculations:
  - Of 408 persons with disabling conditions for whom it had been over a year since they spent a consecutive month in housing:
    - 278 self-reported being homeless for 1-3 years during the past three years.
    - 55 others self-reported being homeless for 7-12 months during that period (and might well be chronically homeless, if they were homeless just prior to their non-housing situation).

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[1] *The definitions used by policymakers are quite different from the definitions used by those surveyed. The self-reported statistics below appear to understate the extent of homelessness. Approximately 3% of the 824 men and women surveyed in the shelters and TH programs where they were staying indicated that they were not currently homeless. While some may truly have had a permanent home, others may have considered themselves "housed" in their transitional housing or long-term shelter bed. Presumably, that perception also explains why 66 (or 8.5%) of shelter and transitional housing survey respondents indicated that they had "never been homeless during the past three years."*

- Of 264 persons with disabling conditions for whom it had been less than a year since they spent a consecutive month in housing, 47 self-reported being homeless for 1-3 years during the past three years.

- The 380 respondents with disabilities and substantial periods of homelessness or non-housing-plus-homelessness represent a conservative estimate of the chronically homeless subset of the total survey population.

  ☞ Note: The estimate ***excludes*****:** (a) people who self-reported a disabling condition, but did not self-report receipt of disability-related benefits or a period of inpatient or residential treatment for their condition(s); as well as (b) people who failed to self-report a disabling condition or who under-reported the extent of their homelessness.

As noted earlier in this document, the MHSA Survey reached only a portion of the older adult homeless population, so the 380 respondents (44.3% of the total 858 survey population and 56% of the "qualified" population) that we estimated to be chronically homeless represent only a portion of the overall number of chronically homeless older adults. If the overall older adult homeless population is more or less comparable to the survey population, then ***we estimate that 40 - 50% of that larger older adult homeless population is chronically homeless.*** While more comprehensive and accurate data would certainly be useful, ***the existence of these 380 chronically homeless older adults by itself constitutes enough evidence of need to justify the development of a distinct response.***

The National Alliance to End Homelessness has documented that this older adult population is growing as a percent of the overall homeless population and in absolute numbers due to a combination of:

- The extreme economic vulnerability of the one-third of the leading edge of the baby boom generation that has negative net worth, and
- The cohort effect of large numbers of mostly minority men who were incarcerated for long periods due to mandatory minimum sentences who never got traction post release in the job market, the marriage market, or the housing market.

IV. Special Needs of Homeless Older Adults and the Importance of a Distinct Strategy

Determining an elderly person's eligibility for financial benefits and securing a stable income is necessary to obtain permanent housing, but can also be especially challenging to the elderly homeless population. In some cases, homeless elders may be unaware of available benefits such as Social Security, Supplemental Security Income, VA pensions, and private retirement pensions. Very low-income older adults may also be eligible for food stamps and/or state-funded public assistance. Many seniors are also unaware of their eligibility for Medicare upon reaching 65. Lastly, very low-income and/or disabled seniors may be eligible for the State-supported Medicaid program and therefore be dually eligible for Medicare/Medicaid.

The necessary follow-up with the application process to secure such benefits requires paperwork and long waits for filing paperwork that someone may find discouraging. Seniors with cognitive disabilities or elderly immigrants faced with changing immigration policies and language limitations face even more challenges when it comes to cultural barriers that may require additional assistance. Along with assistance to secure a stable income, elderly persons, especially those with significant mental health problems, cognitive impairments, or substance abuse problems, may need assistance with money management or benefit from participation in representative payee service. These types of services are not only necessary for housing but can be crucial in helping to ensure that the participant's rent is paid or that their limited income lasts through the month to support the need for food, prescription co-payments, and transportation.

The amount of financial assistance an elderly person receives from Social Security is dependent on the number of years or quarters they have worked and contributed to the Social Security system. The full benefits depend on when the person is eligible by date of birth. However, if one retires before reaching the age of 65 years, the amount they are entitled to receive every month is decreased. Social Security can be supplemented with Supplemental Security Income (SSI) for seniors who are 65 years or older and whose monthly income is below the SSI limit.

For many elderly persons 65 years or older who do not have a work history with Social Security, SSI becomes their primary source of income. The cost of living, including housing and other expenses, is often not sufficiently covered by SSI. One of the barriers is the reluctance and hesitance of many elderly homeless persons to accept any housing that will significantly deplete their Social Security or SSI check. Some older people find it necessary to obtain employment in order to supplement their limited monthly income to meet the costs of basic housing and living. However, seniors may have medical and physical conditions that may make it difficult to work. Many others encounter difficulty in obtaining employment, not because of any physical limitations, but because of their age. While some seniors may access employment training and placement in part-time work, others may face the discriminatory practice of ageism in the job market, which may defeat their attempts to establish or improve their income.

At the heart of our state and national strategy for ending homelessness is the notion of getting homeless people back on their feet, by which we mean not only finding housing, but finding employment and re-engagement with mainstream society. This strategy doesn't work for homeless older adults for several reasons:

- Older homeless individuals are often hidden from our view because of justifiable fear of shelters or other reasons and so are ignored in both the Massachusetts and Federal strategic plans to end homelessness;
- Older homeless adults have been shown to have the range and severity of health issues similar to people in the general population who are 15 years older[2].
- A recent study on geriatric syndromes in homeless adults aged 50-69 in Boston found higher comorbidity rates than among other older adults, including hypertension, asthma or COPD, and depression. Many experience cognitive declines and report binge-drinking[3].
- Older adult homeless individuals often cost more to ignore than to house.
  - A review of 97 participants in the Home and Healthy for Good (HHG) program indicated that housing chronically homeless individuals and providing them with services saves roughly $10,000 in Medicaid costs per beneficiary per year.
  - While the average age of the HHG population was 47, the average chronological age of the surveyed older adult population was 57 with a clinical age of 72 and a much higher level of frailty, disabling conditions and other conditions requiring services to support a successful tenancy. This suggests those surveyed are likely to be high utilizers of costly emergency medical services.
- Challenges with employment were likely to have been part of the reason individuals became homeless in the first instance whether through age discrimination in job searches after layoffs or through poor job performance; success in an already challenging job market for the long term unemployed is extremely unlikely;
- Older adults have a different set of available resources with complex and inconsistent eligibility requirements which often prevent individuals from navigating the bureaucracies offering them;
- Outreach is necessary for successful housing searches for homeless older adults because of a constellation of cognitive challenges, mental health issues, cultural issues, substance abuse issues and others;

[2] **Culhane DP, Metreaux S, Hadley T.Supportive housing for homeless people with severe mental illness.** ***LDI Issue Brief.*** **2002;7(5):1-4.**

[3] **Brown RT, Kiely DK, Bharel M, Mitchell SL. Geriatric syndromes in older homeless adults.** ***J Gen Intern Med.*** **2012;27(1):16-22.**

- Because of the high prevalence of disabling conditions in this population, they have an immediate need for a higher level of services to succeed in housing, and will likely see their service needs increase over time.

V. Best Practices

There have been some efforts both locally and across the country to respond to older adult homelessness and the needs of those who are at risk of being homeless. Some of these are noted here.

National Best Practices:

The New York based **Corporation for Supportive Housing (CSH)** has a project in Columbus, Ohio at the Commons at Buckingham. There are 100 units of housing with 75 units for people who have been homeless. For low income people, including those with disabilities, housing is provided both for former nursing home residents and group home residents as well. Services on site include nursing and home health and intense care management. A medical director oversees monthly interdisciplinary team meetings to assess and develop care plans to meet resident needs. In San Francisco, at Mission Creek Senior Community, 139 units of senior housing include 51 set aside for chronically homeless older adults. Services including a health center are located on site.

Also located in Columbus, Ohio, the **National Church Residences** provides permanent supportive housing for the formerly homeless and disabled with an approach that assumes that people are much more likely to become stable, contributing members of society when they have a safe, affordable place to live. The Permanent Supportive Housing group promotes and improves mental, emotional, physical and financial stability for its residents. It links residents to internal programs and external community resources that assist them in achieving their highest level of self-sufficiency. The activities include: collaborative team meetings; assessment and referral; case management; life skills training; education enrichment; health care education; crisis intervention; employment services; recovery support; financial management assistance; work readiness training; joint property management and services apartment inspections and housing retention/eviction prevention planning. Permanent supportive housing communities are made possible through extensive collaborative partnerships with local and city government, area housing authorities, county commissioners, private foundations (such as CSH) and corporate sponsors.

In Maine, the **Elder Abuse Institute** promotes the awareness and prevention of elder abuse through training, collaboration, outreach and advocacy. The organization was founded as a community coalition in 1995. Since that time the Institute has sponsored statewide conferences, provided train-the-trainer and workplace training workshops, produced public service announcements and established support groups for older victims of domestic violence. In 2010, the Elder Abuse Institute was awarded a grant by the US Department of Justice, Office on Violence Against Women to develop transitional housing options and supportive services for elder victims of domestic violence, sexual assault and stalking. During the last 18 months of operation they served 170 women and men through this program.

In New York, the **West Side Federation for Senior and Supportive Housing, Inc. (WSFSSH)** was formed in 1976 to provide supportive housing that serves older people and those living with other special needs. They specifically target independent seniors, frail elderly individuals, older persons living with serious mental illnesses, homeless individuals, persons living with physically handicapping conditions, grandparents raising their grandchildren, and families. They house over 1,800 people in 24 buildings located on the Upper West Side, and in Harlem, Chelsea, and the Bronx. Services include case management, crisis intervention, money management, assistance in obtaining home care services, counseling, and social activities. However, all services are individualized and engage the older adult in determining what services are utilized[4].

[4] http://www.wsfssh.org/

In addition to these current best practices, New York State's Department of Health (NYSDOH) is committing resources for senior supportive housing through the **Senior Supportive Housing Services Project** RFA Model **(SSHSP)**. NYSDOH is seeking organizations to develop senior supportive housing projects. This model provides a specific outreach mechanism to identify low-income Medicaid eligible seniors who currently are homeless or reside in the community (not currently in low-income senior housing), and who are at risk of nursing home placement and seniors who wish to transition out of nursing homes into community living who require long term care service. NYSDOH have committed $4 million dollars to fund up to eight applicants. Each would be eligible to receive up to $250,000 per year for a two year period to support infrastructure cost (personal and non-personal services), and will support the program to implement all required Scope of Services activities. A portion of the award will also be made available for capital assistance (budgeted under contractual services/subcontracts). Of major significance here is that as states move forward to provide community housing for people who leave nursing facilities, NYS has expanded the population – and their own state dollars – to include people who are homeless[5].

Local Best Practices

The **Journey to Success Program** is a collaborative of the Massachusetts Housing and Shelter Alliance, the Cardinal Medeiros Center and the Department of Public Health, to help chronically homeless people transition out of homelessness. The program puts housing first and then deals with the service needs of the individual. The program is designed to promote integration into the community with flexible case management support and an interdisciplinary service team. This team addresses participants' needs for resources and encourages use of existing support services.

The **Aging Right in the Community (ARC) Project** is a collaborative effort of **Elders Living at Home Program (ELAHP)**, a program of the Boston Medical Center, and the Medical Legal Partnership Boston, providing comprehensive case management and legal services to elders (age 55 and older) with a history and an ongoing risk of recurrent homelessness, and elders whose chronic disabilities put them at risk for losing their housing and becoming homeless. In addition to the case management and legal services, ARC provides nursing, home monitoring and medication management and coordination of services such as primary medical care, mental health and substance abuse treatment, financial management and other services necessary to sustain participants' housing.

ELAHP's Temporary Housing component provided long-term emergency and transitional housing to older adults who became homeless. ELAHP rented 28 one bedroom and studio apartments scattered through four different Boston Housing Authority elderly/disabled developments to house individuals 55+ while they were helped to find safe, affordable permanent housing. ELAHP provided initial screening and assessment in order to place eligible individuals in appropriate units, as well as intensive case management and housing advocacy services to stabilize clients and then support them in their transition to permanent housing. From 1988-2004, the Temporary Housing project served as an alternative to emergency shelter for frail older adults who lost their housing and lacked financial resources and informal supports. In addition, chronically homeless older adults could be housed to help them re-establish their credentials as tenants and rebuild independent living skills to give them the opportunity to access permanent housing. The project served more than 500 older adults, 85% of whom transitioned to safe, affordable permanent housing. The housing retention rate for these individuals was greater than 95%.

Hearth's[6] existing Homelessness Prevention Program, serving at-risk older adults (age 50+), has an enhanced Walk-In component. Hearth's program combines supportive services (privately/philanthropically funded case management, landlord/tenant mediation, advocacy at housing court, and stabilization supports) with last-resort

[5] http://shnny.org/rfps/doh-senior-supportive-housing-services-rfa/

[6] Hearth is a leading Boston-based non-profit provider of permanent supportive housing (PSH) for older adults, maintaining 188 units of PSH in seven different residences. HEARTH also employs a staff of five outreach workers targeting currently homeless older adults, and a one prevention-focused case manager.

financial assistance (Emergency Solutions Grants (ESG) dollars and other funding to cure rental arrearages) to enable vulnerable older adults to sustain tenancies that would otherwise be lost. In 2013, the program served 62 older adults (age 50+). This number included 39 persons who are no longer at risk of homelessness and now need only occasional follow-up case management, and another 23 who remain on the active caseload. The program has an official waiting list of 38 persons, not counting dozens of pending referrals/self-referrals of older adults who are at real risk of losing their housing. At present, the program can only provide four hours per week of walk-in assistance, leaving many other older adults unserved and at risk of homelessness.

Hearth's Permanent Supportive Housing for Older Adults provides 188 units for formerly homeless older adults in seven sites including its award winning newest project, Hearth at Olmsted Green and an accredited assisted living program, Ruggles Assisted Living. All sites are close to public transportation and retail establishments. The average age of Hearth's residents is 67 years and most enter housing with a complex medical history involving multiple chronic illnesses and may have corresponding mental and physical challenges. Supportive services that assist residents to age with dignity regardless of their special medical, mental health, or social needs are provided by nurses, social workers, personal care staff, resident service coordinators and site directors. 40 of Hearth's residents are clients of the Department of Mental Health, and roughly half receive services through the Group Adult Foster Care Program.

Home and Healthy for Good (HHG) is a statewide initiative coordinated by the Massachusetts Housing and Shelter Alliance (MHSA). The program provides housing placement and supportive services, based on Housing First principles, through a network of community-based providers. HHG is particularly noteworthy in its emphasis on tracking the cost impacts of public service usage before and after participants move into permanent housing.

HHG was created by MHSA to "turn the old model on its head" by focusing on immediately placing chronically homeless individuals into permanent housing. In 2007, the Massachusetts legislature passed a line item in the state budget to fund the program as a statewide Housing First pilot, designating MHSA as the administrator of the funds. Since that time, HHG has housed over 750 individuals who were formerly chronically homeless.

Participants in HHG are identified by the local agencies, which provide "low-threshold" access to housing. While all are chronically homeless, about one-quarter of participants are street dwellers who were staying outside prior to moving into housing. Their average length of homelessness is five years.

Participants work closely with a case manager to access a broad range of services, including medical and mental health care, substance abuse treatment, and vocational training. The usage of these services, however, is not a condition of ongoing tenancy. As time in permanent housing increases, health care service usage typically shifts from frequent emergency room visits and inpatient hospitalizations to more traditional primary medical and mental health care. As a result, health outcomes for participants are greatly improved and medical costs decrease significantly.

A. Short-Term Action Plan: 2014

Goal	Action Item	Implementation Lead	Timeline (calendar year)
Increase Awareness of Homelessness Among Older Adults	• Provide information and partnership/opportunities to key stakeholders, including HUD, USICH, American Society of Aging, National Council on Aging, and others.	Older Homeless Adult Working Group	2014
Strengthen Existing Homelessness Initiatives to Include Older Adults as a Priority Population	• Incorporate older homeless veterans into those targeted for housing and services through the *Massachusetts Integrated Plan to Prevent and End Homelessness Among Veterans*. The Steering Committee overseeing plan implementation will charge each working group with assessing the capacity to serve older veterans and identifying action steps for incorporating this population into their initiatives. The Steering Committee will include this in its year one progress report as a recommendation for year two and then report to the Older Adult Working Group against these recommendations quarterly. • Incorporate older homeless adults into the Social Innovation Finance initiative by ensuring homeless adults age 50 and older are included in screenings by SIF providers using the triage and assessment tool. Include questions in the tool that will permit assessors from understanding and identifying unique needs of older adults. SIF's priority on chronically homeless adults and other predicted high-utilizers of emergency services is in line with data indicating older homeless adults often meet the chronic definition and experience significant medical challenges.	ICHH, MHSA, DHCD	2014
Improve Data Quality to Understand the Scope of Homelessness Among Older Adults and Track Progress in Prevention and Rehousing.	• Ensure data elements necessary to understand age, demographics, housing history, and disability status are incorporated into DHCD efforts to improve data quality and analytical capability through HMIS and other strategies. • Partner with the 18 Continuums of Care in Massachusetts as they develop coordinated intake processes to ensure those processes account for the needs of older adults.	ICHH, DHCD, CoCs[7]	2014-2015

[7] Continuums of Care (CoCs) are regional or local planning bodies that coordinate housing and services funding targeted to homeless individuals and families. They are the primary vehicle through which the U.S. Department of Housing and Urban Development provides homeless resources to communities across the country. There are 18 CoCs in Massachusetts.

Build Partnerships to Enhance Coordination and Maximization of Housing and Service Resources	• Create a formal process for connecting Continuums of Care and Home Care providers. • Build partnerships with local housing authorities and private property owners to provide more intensive home- and community-based services designed to maintain tenancies. Services most in need for prioritization include Home Care models, intensive case management, and substance abuse services (both Group Services and SBIRT).	Older Homeless Adult Working Group	2014-2015
Explore Opportunities for Providing Older Adults Who Become Homeless with Safer, More Supportive Alternatives to Emergency Shelter	• Explore current options to create a pilot emergency housing project based on previous models. Identify potential housing options, funding streams and project partners.	EOEA, DHCD	2014-2015

B. Long-Term Action Plan: 2015-2017

Goal	Action Item	Implementation Lead	Timeline (calendar year)
Prevent At-Risk Older Adults from Becoming Homeless	Expand EOEA's Supportive Housing Initiative within additional Local Housing Authority Sites.	EOEA, DHCD	2015
	Build partnerships with local housing authorities and private property owners to provide more intensive home- and community-based services designed to maintain tenancies and home based services. Services most in need for prioritization include Home Care models, mental health services, intensive case management, substance abuse services (both Group Services and SBIRT)	EOEA, DHCD, DPH	2015
	Identify opportunities to expand home-based services for older adults between the ages of 50-54 who are at-risk of homelessness, and not otherwise eligible for such supports.	Older Adult Working Group	2015-2016
	Expand proven community-based prevention best practices to include elders, such as walk-in services, landlord-tenant mediation, housing court advocacy, case management and stabilization. Prevention services should leverage Emergency Solutions Grant funds, and other existing public and private prevention dollars. Services should be accessible within existing community-based provider network.	Older Adult Working Group	2015-2016

	Analyze the feasibility of creating a statewide network of representative payee resources and providers to support vulnerable low-income populations, including at-risk older adults. This should include analysis of funding options, geographic distributions and structure.	Older Adult Working Group, ICHH	2015-2016
Reduce Chronic Homelessness among Older Adults	Expand supportive housing opportunities for chronically homeless adults within public and private subsidized housing developments. Leverage existing programming, such as Home and Healthy for Good, to expand capacity to serve chronically homeless older adults.	DHCD, Interagency Supportive Housing Working Group, MHSA	2016
Serve Homeless and At-Risk Older Adults by Using Triage and Assessment Practices Designed to Ensure Targeted Application of Prevention, Rapid Rehousing, and Stabilization Resources	Develop a strategy for the appropriate administration of a protocol such as the Vulnerability Index developed by Boston Health Care for the Homeless to identify homeless older adults most at risk of premature death.	MHSA	2016-2017

APPENDIX A

ICCH Older Work Group Members

**Co-Chairs*
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